2007-2008 (FFY 07) Funding Guidelines North Carolina Hospital Preparedness Program Grant

I. Overview of the NC Hospital Preparedness Program

In order to provide proper insight for grant applicants regarding these funding guidelines, the following overview is primarily comprised of information contained in the North Carolina grant proposal to the Office of the Assistant Secretary for Preparedness and Response (ASPR). This information should be useful as applicants develop their application.

Long before the terrorist attacks of 2001, the state of North Carolina had taken a proactive approach to emergency preparedness and healthcare system coordinated response. North Carolina has a history of large scale events including hurricanes, floods, and hazardous material releases that have fostered an overall sense of urgency along with developing response experience among the ranks of the healthcare systems. The traditional North Carolina approach to patient safety and continuity of care remains aggressive, coordinated, and very successful.

Major accomplishments over the last several years are largely attributed to the Hospital Preparedness Program (HPP), the Centers for Disease Control (CDC) Public Health Preparedness Cooperative Agreement, and the State Homeland Security Grant Program (SHSGP). These funding sources and others have been leveraged with the Urban Area Security Initiative (UASI), Cities Readiness Initiative (CRI), Metropolitan Medical Response Systems (MMRS), and Pandemic Flu appropriations to create the North Carolina State Medical Response System (SMRS).

The SMRS is made up of various components of North Carolina's many healthcare systems and partners. These response partnerships consist of personnel that vary from Trauma Surgeons to professional mechanics. The SMRS is composed of hospital employees, public health employees, private medical clinical service employees, and a large amount of true volunteers. Volunteers bring both medical and non-medical training and experience to the system. The system is further divided into State Medical Assistance Teams (SMAT)s and Medical Reserve Corps (MRC)s.

The SMRS is managed per the National and State Response Plans by Emergency Support Function number 8 (ESF-8). The lead agency tasked to manage and coordinate ESF-8 and the awardee of all previous HPP cooperative agreements is the North Carolina Office of Emergency Medical Services (NC OEMS). NC OEMS lies within the Division of Health Service Regulation (formerly the NC Division of Facility Services) and the North Carolina Department of Health and Human Services.

The North Carolina HPP has remained on target through all previous program guidance documentation. The program has consistently met minimum levels of readiness; utilized performance based tracking and monitoring, and coordinated system development to achieve defined capabilities per the National Preparedness Goal and associated Target Capabilities List. The SMRS and North Carolina ESF-8 are fully

regionalized by the design and implementation of eight Regional Advisory Committees (RAC)s. Based on the statewide Trauma Care Network and daily emergency patient flow patterns, eight regions were designated. Each region retains a designated trauma center as its lead and provides the forum for regional Disaster Preparedness Committee meetings. Members of the RAC are not limited to hospitals, but encompass all healthcare system entities and their partners. Planning initiatives and preparedness activities are also coordinated through this RAC.

North Carolina's grant proposal included several projects to expand into areas identified by gap analysis and Corrective Action Plans (CAP)s, and broadening the foundation of the NC SMRS. These projects were developed based on the NC State Strategic Plan cross walk with multiple initiatives, federal cooperative agreements, lessons learned, and after action reviews.

NC OEMS will lead the inter-state effort of the Region IV ESF-8 Unified Planning Coalition to develop a regional burn plan, increase capability, increase burn surge capacity, and facilitate training at the local level on the process. A learning management system will be developed to track training and exercises for both reporting and intra-state analysis. Tracking training by several data points will provide increased visibility on current capabilities and future needs. This system can be augmented from several other funding sources to track the same data elements for other partners as well.

The Medical Reserve Corp (MRC) is being incorporated into the SMRS and funding will facilitate consolidated training to aid in this process. The Medical Reserve Corps from across the state will receive specific invitations to join ESF leadership and emergency management at several educational summits. Specific integration based education will be offered to the MRC as well. North Carolina is also partnering with faith based response groups such as the North Carolina Association of the Baptist Men. A unique partnership has been formed for medical care provision and the state will be utilizing the various overseas deployment experiences from this group to strengthen the program. The North Carolina Baptist Men have also applied for MRC status and will formalize their agreement with NC OEMS in the near future.

The ESAR-VHP solution for North Carolina is entitled ServNC. It can be viewed at www. servnc.org and has been operational since May 2007. The ServNC system meets all current ESAR-VHP compliance documentation and has been tested several times. This system utilizes multi-focal two way communications that rival most state's Health Alert Networks. The system retains all team compositions while allowing management to form mission specific rosters based on one or more of the 50+ data elements gathered on each responder. Responders retain the right to refuse deployment and are categorized by their willingness to travel and deploy for extended stays. The system is also fully integrated with various state credentialing authorities for real time verification and validation. Various state agencies and response entities are now purchasing vendor packages that allow them to join this system. The goal is to have all State volunteers in one system with each ESF managing its relevant track of volunteers. There may also be a need to add additional regional and local partners to ServNC.

As with all emergency planning, preparedness, and response activities, planning remains the most crucial element of preparedness and program direction. North Carolina will be devoting key assets to planning activities that allow for large scale use of Alternate Care Sites (ACS)s. This is a statewide initiative and will provide 58+ large scale locations for medical surge capacity when complete. A tremendous planning effort is underway to secure these locations and provide the necessary plans to make them viable if needed. These sites will augment local and regional surge capacity efforts and provide a healthcare system decompression capability that currently does not exist. Regional and local resources are critical to the success of this initiative.

The NC OEMS will also be leading the effort in Continuity of Operations Planning (COOP) for ESF-8. It is imperative that access to health care not be compromised any more than absolutely necessary during events of any magnitude on any scale. In order to ensure this, services other than emergency services must plan for continuity during emergency events. The failure to do so will constitute additional emergencies and collapse an already fragile system. NC OEMS will lead the development of a comprehensive ESF-8 COOP for Health and Medical response partners on the local, regional, and state level during this funding cycle.

North Carolina also recognizes the need to ensure healthcare facility evacuation plans are adequate, plausible, viable, and exercised to a degree of comfort to ensure when activated, they are successful. Funding is requested to facilitate the review of all hospital evacuation plans, crosswalk expected assets for "multiple allocation", and make corrective action recommendations. When possible, these plans will be tested through exercise so that formal AARs may be developed to assist local facilities in evacuation planning efforts.

One of the top priorities is education and preparedness training. A majority of the projects are devoted entirely or in part, to developing and implementing preparedness education to healthcare providers and healthcare system partnerships. Training will be held to facilitate long term care planning and SMRS integration for home health and hospice. These groups are being specifically targeted to assist in the planning and response to care for the at risk population of our state. The SMRS SMAT training will be revamped to a more contemporary version based on lessons learned, National Incident Management System (NIMS), and federal guidance. A small reorganization project that includes a heavy training component will bind medical teams to Urban Search and Rescue (USAR), and Hazmat Teams at the regional level.

Efforts will begin to develop and implement standardized ESF-8 command, control, and responsibilities based training across the state. This is a much needed step to move toward (NIMS) compliance and true standardization per the National Response Plan. Summits will be held to bring all partners together to better integrate healthcare systems and emergency management. These summits will also be used as an opportunity to deliver clinical education and offer training across all healthcare disciplines relevant to emergency response.

Funding to exercise the concepts and plans that have been developed thus far has been requested. A metered approach will be implemented with all types of exercises that culminate with a full scale exercise with specific objectives aimed at testing key concepts and integration measures taken thus far. Just in Time (JIT) training will also be developed and tested to ensure not only professional emergency response personnel are utilized, but that NC has the capability to capitalize on all volunteers willing to assist or individuals that may need to perform outside their normal zone of comfort.

Data systems play a vital role in the response capabilities of the North Carolina SMRS. The state has developed several systems including asset tracking, personnel tracking, patient tracking, credentialing, mission tasking, GIS mapping and others. These systems are being expanded to include more healthcare partners and augmented to allow more healthcare partners to use them. These systems are also being funded to integrate all data systems. NC OEMS has partnered with State Emergency Management (NCEM) to integrate all response data systems and provide a more robust, more efficient, database architecture to assist in the coordination of health and medical assets during disasters or other opportunities of patient surge.

Pharmaceutical access problems are a common factor in all medical response scenarios. North Carolina has acquired the technical expertise to assist in pharmaceutical related projects, planning, exercises, and general policy development. The coordination of the Strategic National

Stockpile (SNS) and other public health pharmaceutical related initiatives require dedicated support from the medical response community. NC OEMS has also partnered with the State Homeland Security Grant Program (SHSGP) to produce three mobile emergency dispensing and compounding units. These units must be designed, built, and deployed. Lastly, the SMRS has over 40 medicinal caches around the state not including any CDC funded caches such as Chempack, antivirals, or antibiotics. These response formularies must be maintained with general oversight and change in design as needed based on current Hazard Vulnerability Assessments (HVA)s and intelligence.

It is important for grant applicants to understand and incorporate where possible the federal and state focus of the hospital preparedness program as regional and local projects are developed.

II. Funding Methodology Based on Capability Elements

The methodology for distribution and use of the National Bioterrorism Hospital Preparedness Program (NBHPP) funding for the RACS will be similar to the previous year as grant funds will be distributed to the eight RACs via the lead hospitals to support projects and programs consistent with federal and state guidelines. Funding allocations are based on the process used last year by determining the number of hospital emergency department visits in the RAC and the population and total square miles for each county affiliated with the RAC.

Funding is again directed towards building Medical Surge. The following is the definition for Medical Surge taken from the Target Capabilities List:

> Medical Surge is the capability to rapidly expand the capacity of the existing healthcare system (longterm care facilities, community health agencies, acute care facilities, alternate care facilities and public health departments) in order to provide triage and subsequent medical care. This includes providing definitive care to individuals at the appropriate clinical level of care, within sufficient time to achieve recovery and minimize medical complications. The capability applies to an event resulting in a number or type of patients that overwhelm the day-to-day acute-care medical capacity. Planners must consider that medical resources are normally at or near capacity at any given time. Medical Surge is defined as rapid expansion of the capacity of the existing healthcare system in response to an event that results in increased need of personnel (clinical and non-clinical), support functions (laboratories and radiological), physical space (beds, alternate care facilities) and logistical support (clinical and non-clinical equipment and supplies).

The current federal grant guidance no longer addresses critical benchmarks, tiers, or required scenarios but rather stresses capabilities. Applicants should develop their projects based on the following capabilities.

A: Level One Required Sub-Capabilities

Applicants should use funds for the following sub-capabilities if the capabilities have not been met. If all level one capabilities have been met or will be completed by August 8, 2008, funds can be directed towards level II sub-capabilities

Interoperable Communications System - This system shall connect the healthcare system both horizontally and vertically to the tiered response system outlined in the Medical Surge Capacity and Capability (MSCC) handbook and the FY 2006 HPP program guidance (previously known as the National Bioterrorism Hospital Preparedness Program guidance).

During the past grant years, significant funding has been expended to provide for a statewide interoperable communications systems. Applicants should review their current regional and local status to determine if there are additional project(s) that should be funded to more fully meet this capability. All communications projects must be approved by the SMRS communications subcommittee and OEMS before expenditure of funds can take place. This will ensure true interoperability and standardization.

Bed Tracking System - This system shall be capable of reporting bed categories that are consistent with Hospital Available Beds in Emergencies and Disasters (HAvBED) requirements and definitions.

North Carolina has a system (State Medical Asset Resource Tracking Tool – SMARTT) that meets the HAvBed requirements and definitions. Currently hospitals and EMS systems are participating in SMARTT as well as a few Community Health Centers. Applicants should consider a project(s) that would encourage long-term care facilities, mental health facilities and dialysis centers to participate in SMARTT once the modules become available. The applicant must demonstrate that ALL hospitals are currently participating in the SMARTT system and ALL prior participation in the Hospital Status System has ceased.

Emergency Systems For Advance Registration of Volunteer Health Professionals (ESAR-VHP) - Recipients shall have a fully operational Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) system.

North Carolina has a system (ServNC) that meets the requirements of ESAR-VHP**. *This capability element will not be eligible for funding and is considered completed by the state.***

Fatality Management Plans - All participating hospitals must possess and exercise fatality management plans that are integrated into the local jurisdiction and RAC plans for the disposition of the deceased. States should work closely with hospitals to ensure integration of these plans. Fatality Management planning will be an eligible expense.

North Carolina's mass fatality capability is currently being updated by projects that have just been initiated to increase the partnerships, training, equipment and other resources required for mass fatality. All proposed project(s) must be integrated and coordinated with the state plan and associated projects.

Hospital Evacuation Plans - All participating hospitals must possess and exercise evacuation plans that are integrated in the local jurisdiction and State plans for moving patients. States should work closely with hospitals to ensure integration of these plans.

All licensed facilities are required by law to have an evacuation plan and the plan must be provided to the local emergency manager for review. Evacuation plans are routinely tested through exercise and training programs, and corrective actions are then implemented. North Carolina will initiate a statewide project to provide for a technical review and aggregate comparison of hospital evacuation plans to ensure planning principles will be adequate for evacuations caused by All Hazards. All proposed projects must be integrated and coordinated with the statewide project.

B: Level Two Sub-Capabilities

Applicants can use funds for the following sub-capabilities *only if* they can clearly demonstrate and provide a statement that all Level-One Capabilities have either already been met or are prioritized in such a way that they will be completed by August 8, 2008.

Alternate Care Sites (ACS) - Establishment of alternate care sites – ACS (e.g., schools, hotels, airport hangars, gymnasiums, armories, stadiums, convention centers) is critical to providing supplemental surge capacity to the healthcare system, with the goal of providing care and allocating scarce equipment, supplies, and personnel. Planning should therefore include thresholds for altering triage algorithms and otherwise optimizing the allocation of scarce resources. Effective planning and implementation will depend on close collaboration among State and local health departments (e.g., State Public Health Agencies, State Medicaid Agencies, State Survey Agencies), provider associations, community partners, and neighboring and regional healthcare facilities. RACs should use FY 2007 funding to continue work begun in previous years and continue to identify gaps regarding ACS within its current system.

Mobile Medical Assets - Awardees must have the ability to provide care outside of the hospital or healthcare system. Use of mobile medical assets may be an option for some jurisdictions until large population centers can be evacuated to outlying less affected areas with intact healthcare delivery systems. States may continue to develop or begin to establish plans for a mobile medical capability, working with State and local stakeholders to ensure integration of plans and sharing of resources. Mobile Medical plans must address staffing, supply and re-supply, and training of associated personnel. M8 Phase II equipment will be an eligible expense for this grant.

Pharmaceutical Caches - Each award recipient may develop an operational plan that assures storage and distribution of critical medications through the supply chain during an emergency for healthcare providers and their families in a timely manner. Although many RACs should already have caches in place due to the multiple years of funding for this activity, States may continue to establish or enhance caches of specific categories of pharmaceuticals available on-site in hospitals, cached within regions or at the State level that would be accessible during an event. FY 2007 funding can be used to purchase pharmaceuticals only if the purchases are clearly linked to a Hazard Vulnerability Assessment (HVA) and gaps identified that show where and why sufficient quantities do not currently exist. Caches should be placed in strategic locations based on the same HVA and stored in appropriate conditions to rotate stock and maximize shelf life. Designation of emergency contacts that will have access to the cache in addition to a contingency plan for access, should be developed. On-site caches or an increase in stock levels within a healthcare facility would assure immediate access to the medications. It is understood that hospital space is limited; therefore, caches may be stored on a regional or state-wide basis. If caches are located regionally or at the State level, a plan should be developed that would assure the integrity of the supply line and how it will be managed in an event. Mutual aid agreements may need to be developed to assure that access to the caches is timely for all healthcare centers. States should coordinate these efforts through the Strategic National Stockpile (SNS). RACs are encouraged to work with stakeholders (Schools of Pharmacy, State Boards of Pharmacy, hospitals, pharmacy organizations, public health organizations and academia) for guidance and assistance in identifying medications that may be needed and a plan to provide access to all healthcare partners during an event. States should also work with these stakeholders to develop training and education for healthcare providers on the available assets and how those assets would be utilized to maximize response efforts. Applications requesting funds for this capability must contain current cache allocations, storage location, and expiration of pharmaceuticals.

Allowable purchases:

The following are allowable purchases to provide for hospital personnel (medical and ancillary), hospital based emergency first responders and their families (both pediatric doses and adult doses shall be considered). RACs may consider a phased approach for pharmaceutical purchases in the following order of precedence:

1) Antibiotics for prophylaxis and post-exposure prophylaxis to all biological agents for at least three days.

2) Nerve agent antidotes either with or without the use of CHEMPACK.

3) Antivirals: In general, the purchase of antivirals is allowed through the HPP, however, purchases are limited to treatment purposes only and are limited to coverage for hospital staff and their family members and hospital based EMS providers and their family members. Purchases for prophylaxis and for populations outside of those identified are not allowable at this time. Plans should consider the following: cost, dispensing prioritization, storage location, rotation of stock and distribution mechanisms. Purchases must be coordinated with the CDC and their efforts through the Pandemic Influenza Supplemental Funding and the HHS Subsidy Program.

4) Medications needed for exposure to other threats (i.e., radiological events).

5) Mobile asset pharmaceutical caches as approved by the SMRS Lead Pharmacist and OEMS.

Personal Protective Equipment - Each recipient should ensure adequate types and amounts of personal protective equipment (PPE) to protect current and additional healthcare personnel during an incident. The amount should be tied directly to the number of healthcare personnel needed to support bed surge capacity during an MCI. In addition, recipients should develop contingency plans to establish sufficient numbers of PPE to protect both the current and additional healthcare personnel expected in support of the events of highest risk identified through a State-based HVA or assessment work. The level of PPE should be established based on the HVA and the level of decontamination that is planned in each region. For example, those hospitals that have identified probable high-risk scenarios (i.e., the hospital functions near an organophosphate production plant with a history of employee contamination incidents) should have higher levels of PPE, and more stringent decontamination processes.
Equipment purchased under this sub-capability should be interoperable with equipment purchased with funds from the DHS State Homeland Security Grant Program (SHSGP) Standardized Equipment List (SEL) for first responders. This list is accessible through the DHS Responder Knowledge Base. Please login as a guest on their website at https://www.rkb.mipt.org.

Decontamination - Each recipient should ensure adequate portable or fixed decontamination system capability exists Statewide for managing adult and pediatric patients as well as healthcare personnel, who have been exposed during a chemical, biological, radiological, or explosive incident. The level of capability should be in accordance with the number of required surge capacity beds expected to support the events of highest risk identified through a State-based HVA or assessment work. All decontamination assets shall be based on how many patients/providers can be decontaminated on an hourly basis. According to the *Occupational Safety and Health Agency (OSHA) Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances*, "All participating hospitals shall be capable of providing decontamination to individual(s) with potential or actual hazardous agents in or on their body. It is essential that these facilities have the capability to decontaminate more than one patient at a time and be able to decontaminate both ambulatory and stretcher bound patients. The decontamination process must be integrated with local, regional and State planning."

The OSHA best practices guide can be found at http://www.osha.gov/dts/osta/bestpractices/firstreceivers_hospital.pdf. Equipment purchased under this sub-capability should be interoperable with equipment purchased with funds from the DHS State Homeland Security Grant Program (SHSGP) for first responders. This list is accessible through the DHS Responder Knowledge Base. Please login as a guest on their website at https://www.rkb.mipt.org. In addition, the American Society for Testing and Materials (ASTM) International Subcommittee Decontamination (E54.03) has established tasks groups around decontamination standards development:

- E54.03.01 – Biological Agent Decontamination;
- E54.03.02 – Chemical Agent Decontamination;
- E54.03.03 – Radionuclide and Nuclear Decontamination; and
- E54.03.04 – Mass Decontamination Operations.

Please visit the ASTM website at http://www.astm.org.

Current decontamination stockpiles are considered adequate and extensive justification may be needed to fund additional decontamination equipment.

C: Overarching Requirements

The following four sub-capabilities must be incorporated into the development and maintenance of all the sub-capabilities being built in at the state, regional, local levels: (1) NIMS; (2) Education and Preparedness Training; (3) Exercises, Evaluation and Corrective Actions; and (4) Needs of At-Risk Population.

1. National Incident Management System: In accordance with Homeland Security Presidential Directive (HSPD) -5, NIMS provides a consistent approach for Federal, State, and local governments to work effectively and efficiently together to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. As a condition of receiving HPP funds, recipients shall be NIMS compliant, and work to assure sub-recipients continue adopting and implementing NIMS compliance activities as outlined in FEMA, National Integration Center, Incident Management Systems Division document entitled "NIMS Implementation Activities for Hospitals and Healthcare Systems" found at http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf. **In FY 2006, States were required to complete elements 7, 9, 10 and 11. Please provide a statement that confirms the State has met these requirements as described in the FY 2006 HPP guidance, or funds will be withheld until the requirement is met.**

In accordance with the eligibility and allowable uses of funds awarded through this announcement, recipients shall direct FY 2007 funding towards finishing the remaining NIMS implementation activities for hospitals and healthcare systems by August 8, 2008. These NIMS compliance activities can be within the FEMA, National Integration Center, Incident Management Systems Division document entitled "NIMS Implementation Activities for Hospitals and Healthcare Systems" found at http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf.

Hospital and healthcare systems refer to all facilities that receive medical and trauma emergency patients on a daily basis. These terms do not include nursing homes, assisted living communities, long-term care facilities, and specialty hospitals (i.e. psychiatric, rehabilitation facilities). However, these facilities are strongly encouraged to work with local hospitals and emergency management to integrate applicable elements of NIMS Implementation (i.e. planning, communications, resources).

RAC applications should include a letter of NIMS compliance status indicating compliance with capability elements 7,9,10, and 11. This letter should also contain the RAC's plan to ensure compliance with the remaining NIMS elements by the end of the grant period.

2. Education and Preparedness Training: Recipients shall assure that education and training opportunities or programs exist for adult and pediatric pre-hospital, hospital, and outpatient healthcare personnel that will respond to a terrorist incident or other public health emergency, around the sub capabilities described in the FY 2007 HPP guidance. Also, recipients shall undertake activities to ensure all training opportunities or programs (including those in local health departments, major community healthcare institutions, emergency response agencies, public safety agencies, etc.) collectively enhance the ability of workers to respond in a coordinated, non-overlapping manner that minimizes duplication and fills gaps in the event of a bioterrorist attack or other public health emergency. The award recipient shall describe how the education and training activities discussed in their work plan will be linked to exercises/drills and with the overall State/jurisdiction preparedness plan. FY 2007 funds may be used to offset the cost of hospital personnel participation in training, around sub-capability development, to prepare staff with the necessary knowledge, skills and abilities to perform/enhance the capability, in addition to

participating in drills and exercises. The HPP fully expects that recipients will work closely with their sub-recipients in determining cost-sharing arrangements that will facilitate the maximum number of personnel being able to participate in drills and exercises. As in previous years, release time for staff to attend trainings, drills and exercises is an allowable cost under the cooperative agreement. **Salaries for back filling of personnel are not allowed.** Recipients shall develop a system for tracking all HPP funded training, drills and exercises. This system shall detail the subject matter, the date of the training, the objectives of the training, and the number trained by healthcare specialty. RAC applications should specifically indicate how education and training efforts will be directed toward the recruitment and retention of SMAT IV personnel from the LTC, Home Health, and Hospice communities. The RAC budget for education should also include sufficient funding for a significant amount of regional and statewide training such as M8, ESF-8, EM today, and other training opportunities.

3. Exercises, Evaluations and Corrective Actions: The RACs application should include sufficient funding to attend and participate in no less than 2 statewide exercises which may include significant team participation. Additional activities for funding consideration under this capability include:

- Enhancement and upgrade of emergency operations plans based on the exercise evaluation and improvement plan.
- Release time for staff to attend drills and exercises. **Salaries for back filling are not allowed costs under the cooperative agreement.**
- Costs associated with development of exercises and drills such as fuel, maintenance, etc.

The Homeland Security Exercise and Evaluation Program (HSEEP) During the FY 2008 program and budget year, exercise programs funded all or in part by HHS HPP cooperative agreement funds will have to demonstrate full compliance with the Homeland Security Exercise and Evaluation Program (HSEEP). **In anticipation of this requirement HHS strongly encourages all awardees in FY2007 to begin developing an exercise program capable of being fully compliant with HSEEP in order to meet the requirements of the FY2008 program year.** The HSEEP is a capabilities and performance-based exercise program. The intent of HSEEP is to provide common exercise policy and program guidance capable of constituting a national standard for all exercises. HSEEP includes consistent terminology that can be used by all exercise planners, regardless of the nature and composition of their sponsoring agency or organization. HSEEP compliance is defined as adherence to specific HSEEP-mandated practices for exercise program management, design, development, conduct, evaluation and improvement planning. In order for an entity to be considered HSEEP compliant an awardee will have to satisfy four distinct performance requirements:

1) Conduct an annual training and exercise workshop and develop and maintain a multi-year training and exercise plan.

2) Planning and conducting exercises in accordance with the guidelines set forth in HSEEP Volumes I-III.

3) Developing and submitting a properly formatted After-Action/Improvement Plan (AAR/IP). The format for the AAR/IP is found in HSEEP Volume III.

4) Tracking and implementing corrective actions identified in the AAR/IP.
Additional information on HSEEP is available at https://hseep.dhs.gov/.

4. Needs of At-Risk Population: Considerations for at-risk populations must be addressed when developing response plans. All goals, objectives and activities proposed in the application should account for the public health and medical needs of at-risk individuals. Medical needs include behavioral health consisting of both mental health and substance abuse considerations. Section 2802(b)(4)(B) of the PHS Act defines at-risk population as, "children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency." North Carolina has expanded this definition to include evacuated personnel from the home that require medical support.

III. Interim National Preparedness Goal and the Target Capabilities List

On March 31, 2005, the Department of Homeland Security (DHS) issued the *Interim National Preparedness Goal* (the Goal). The Goal establishes a vision for national preparedness including National Priorities. The *Target Capabilities List* (TCL) identifies 37 capabilities integral to Nation-wide all hazards preparedness, including acts of terrorism.

As of September 2007, the NPG has been replaced with the National Preparedness Guidelines

Publication of the Guidelines and Target Capabilities List fulfills a major component of Homeland Security Presidential Directive 8, "National Preparedness," and establishes a framework for understanding what it means for the nation to be prepared for all hazards. There are four critical elements to the National Preparedness Guidelines:

1. **The national preparedness vision**, which provides a concise statement of the core preparedness goal for the nation.
2. **The fifteen National Planning Scenarios**, which collectively depict the broad range of natural and man-made threats facing our nation and guide overall homeland security planning efforts at all levels of government and with the private sector. They form the basis for national planning, training, investments and exercises needed to prepare for emergencies of all types.
3. **Universal Task List (UTL)**, which is a menu of some 1,600 unique tasks that can facilitate efforts to prevent, protect against, respond to and recover from the major events that are represented by the National Planning Scenarios. Although no single entity will perform every task, the UTL presents a common language and vocabulary that supports all efforts to coordinate national preparedness activities.
4. **Target Capabilities List (TCL)**, which defines 37 specific capabilities that states and communities and the private sector should collectively develop in order to respond effectively to disasters.

The Guidelines and the TCL establish a common planning framework in which agencies at all levels of government and across all disciplines can operate. This framework serves to guide agencies and their constituents in appreciating their unique contributions while working toward a goal shared by all. This new strategic framework provides the Nation with an opportunity to begin viewing programs that have traditionally been managed within one particular agency or discipline in a more holistic and connected manner. Only when programs are managed and

implemented through an interdisciplinary and multi-jurisdictional approach can the Nation truly begin to operate in the coordinated fashion that an incident of national significance will demand.

IV. Regional Approach to Planning

This regional approach will require close coordination with State and Local Public Health Directors, State and County Emergency Management, Law Enforcement, NC Office of Emergency Medical Services, other State and County agencies as appropriate, Community Health Centers, Rural Health Centers, private medical providers and especially the other RACs.

It is imperative that all levels of the medical response and care systems in the RAC are continually exercised and drilled to identify gaps or weaknesses so they can be addressed and strengthened. Hospitals, EMS Systems, Community Health Centers, and Rural Health Centers must adopt an Incident Command System (ICS), continually train and exercise employees on ICS and to incorporate ICS into their emergency response systems. In addition, hospitals and other healthcare providers should collaborate with their local and regional Emergency Managers. Exercises should be done in conjunction with other response agencies and organizations to best judge the entire response system as well as to leverage their funding sources.

V. Capabilities Based Planning

Implementing a shared approach to achieving national preparedness requires the Nation to re-orient its programs and efforts in support of the *National Preparedness Guidelines (NPG).* The Guidelines establish a vision for preparedness, identifies Target Capabilities, provides a description of each capability, and presents guidance on the levels of capability that Federal, State, local, and Tribal entities will be expected to develop and maintain. Capabilities-based planning is a process by which to achieve the Goal and the capabilities it outlines. Capabilities-based planning is defined by the Goal as, "planning, under uncertainty, to provide capabilities suitable for a wide range of threats and hazards while working within an economic framework that necessitates prioritization and choice." This planning approach assists leaders at all levels to allocate resources systematically to close capability gaps, thereby enhancing the effectiveness of preparedness efforts.

At the heart of the Guidelines and the capabilities-based planning process is the TCL. To ensure that the proper capability is being addressed and gaps identified, the State and County HVAs and ASPR Grant 2005 - 2006 Survey need to be applied to the scenario and Level 1 and Level 2 sub-capabilities associated with the greatest threat. Capabilities-based planning is illustrated in Figure 1.

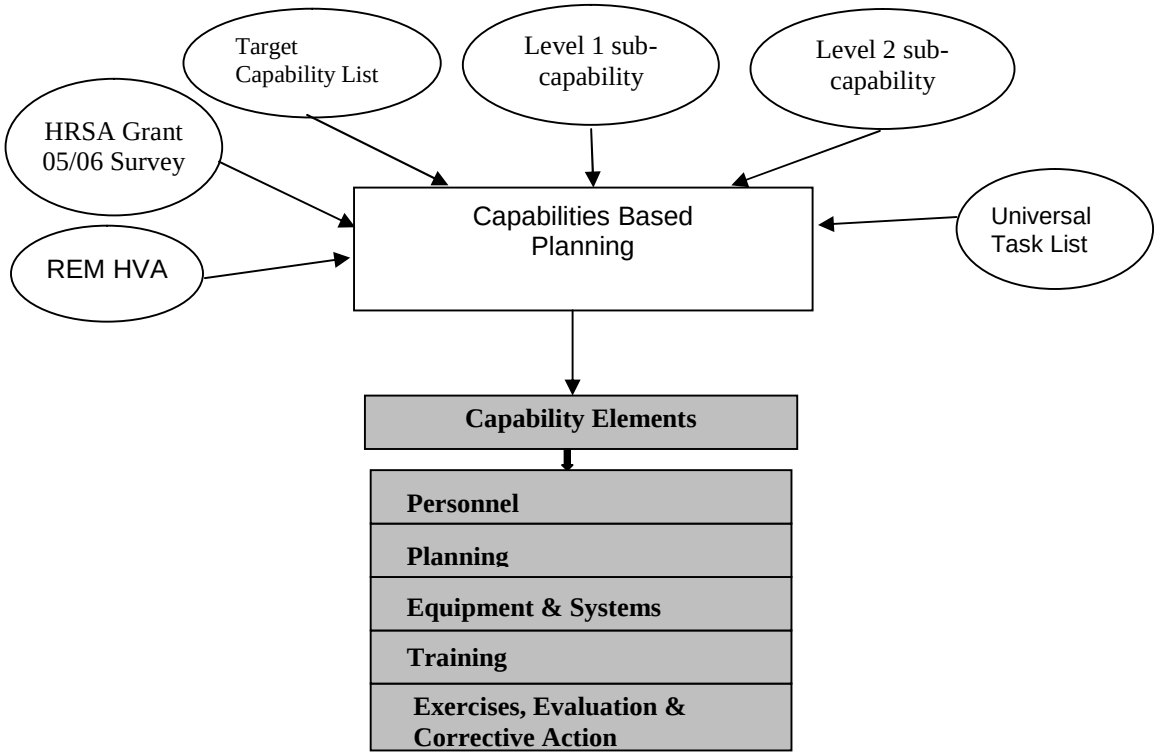

Figure 1
Capabilities Based Planning

Capabilities-based planning will provide a means for your region to achieve the Guidelines by answering three fundamental questions:

1. How prepared do we need to be?
2. How prepared are we?
3. How do we prioritize efforts to close the gap?

The capabilities-based planning process makes significant use of the TCL which provides additional levels of detail on the underlying tasks and resources for achieving these capabilities. **The TCL Draft Version September 2006, Medical Surge Capability pages 495 to 511 can be found on the NCOEMS HRSA Grant webpage.** In this document you will find the Critical Tasks and Performance Measures to assist you in developing your grant projects. Capability-based planning necessitates the prioritization of resources and initiatives among the various capabilities. Given limited time and resources, you will be expected to target your planning efforts on the most critical capability gaps. The expectation will vary based upon the risk and needs of hospitals, EMS systems, and other healthcare entities in your RAC. The State and County HVAs, the regional and local progress made during the 2006-2007 grant cycle and the results of your ASPR Grant 2005 - 2006 Survey

will drive the capabilities needed by the RAC's healthcare entities. For example, a community with a toxic chemical manufacturer must utilize the State and County HVAs, measure the potential health consequences of a chemical release and develop/acquire the capabilities and sub-capabilities needed for the health system response to the specific consequences.

VI. Capability Elements

In each application, the RACs will describe what currently exists in terms of the sub-capabilities described in these guidelines. In addition to addressing the system flexibilities that will change to meet the sub-capabilities, applicants should also incorporate the differences needed for the following capability elements:

1. Personnel
2. Planning
3. Equipment & Systems
4. Training Exercises,
5. Evaluation & Corrective Action

The capability elements and their associated components are defined below:

1. **Personnel –**EMAC/MRC/Other volunteers/Medical Advance or Strike Teams
2. **Planning –** Mobile Medical Facilities/Mass Fatality Plans/Evacuation Plans/Medical Surge Plans
3. **Equipment and Systems –** Decontamination/Isolation/Pharmaceutical Caches/Interoperable Communications/PPE/Hospital Labs Transportation of Special Medical Needs Populations during an event that requires mass evacuation.
4. **Training –** Competency based
5. **Exercises, Evaluations and Corrective Actions –** Entities within the RAC will have to demonstrate their capabilities through State and intrastate regional and local exercises.

For each of the capability elements there are a number of components associated with that element that must be addressed in the RAC grant application. For each project that the RAC intends to complete using ASPR grant funding, the RAC must show in its application:

- That not only the capability element and its associated components are eligible for funding but they must be clearly linked to a State or County HVA or HRSA Grant 2005 - 2006 Survey gap analysis to show that there is still an unmet need.
- Each capability element and its associated components must be linked to the specific TCL's Critical Task that it is addressing

Each RAC will develop their projects based on their State or County HVAs, regional and local progress made during the 2006-2007 grant cycle, HRSA Grant 2005 - 2006 Survey, the Medical Surge Capacity from the TCL, the capability elements and their associated components, and the medical surge capacity section of their regional disaster plan.

It may be beneficial to the RACs, local entities, and counties to develop projects that will have a significant regional impact, e.g. fewer specific projects for individual counties and hospitals, and larger projects that will positively impact regional response and recovery. This will provide for the most efficient administration of the grant funds and have the greatest impact on regional response and recovery.

VII. Steps for Completing Application

- *Step 1*

Each RAC must convene a Disaster Preparedness and Response Grant Committee (DPRGC). The DPRGC should reflect the composition of the RAC and at a minimum will include representatives from a rural hospital, trauma center, a rural and urban EMS System, any State or Veterans Administration hospitals in the RAC, a Community Health Center, a Rural Health Center, a private practice physician, Tribal community (if applicable), county Emergency Management, a 911 Center, a Public Health Regional Surveillance Team (PHRST) within the RAC, Long Term Care representative, Home and Hospice representative, and a representative from the Emergency Management Branch Office. The goal of the DPRGC should be to be as inclusive as possible. While it is essential to include all entities involved in emergency preparedness, this particular grant is not intended to provide funding to fire and law enforcement services unless they are part of EMS system response in providing medical surge capacity. The Disaster Medical Specialist and Regional Manager from NCOEMS shall be notified of any DPRG Committee or sub-committee meetings.

Regional Managers & Hospital Preparedness Specialists

Eastern Regional EMS Office	Central Regional EMS Office	Western Regional EMS Office
Keith Harris **Regional Manager** **keith.harris@ncmail.net** **(252) 355-9026**	**Michael Cobb** **Regional Manager** **michael.cobb@ncmail.net** **(919) 715-2321 ext.201**	**Danny Harbinson** **Regional Manager** **danny.harbinson@ncmail.net** **(828) 669-3381**
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When determining which projects are to be completed in grant year 2007-2008, each RAC must address the Medical Surge Capability section in the TCL (Pages 495 to 511). The projects must then indicate the Critical Task it is addressing and how the Critical Task relates to either a Level 1 (Interoperable Communications System (L1ICS), Bed Tracking System (L1BTS), ESAR-VHP System (L1EVS), Fatality Management Plans (L1FMP), Hospital Evacuation Plans (L1HEP) or Level 2 sub-capability (Alternate Care Sites (L2ACS), Mobile Medical Assets (L2MMA), Pharmaceutical Caches (L2PC), Personal Protective Equipment (L2PPE), Decontamination (L2D). The project must also indicate the capability element(s) the project supports (Personnel (PER), Planning (PLN), Equipment & Systems (EQ/SYS), Training (TRNG) or Exercise, Evaluation & Corrective Action (EE&CA)).

Example: The DPRGC determines that additional resources are need to staff and equip four pre-existing alternate care facilities in the RAC.

TCL Critical Task: Res.C1b 1.3.11Develop plans to identify staff, and equipment and resources to operate alternate care facilities, medical mutual aid agreements for medical facilities and equipment. (TCL Page 496)

Sub-Capability Element: Level 2 (L2) Alternate Care Sites (L2ACS)

Capability Element: (PER) Personnel

Project Name: Alternate Care Facility – Staffing and Equipment

P/P# Res.C1b 1.3.11-L2ACS-PER/EQ/SYS
To determine the P/P number, use the following format:
TCL Critical Task Number-Sub-Capability Element abbreviation-Capability Element abbreviation

Hospitals and EMS systems must meet the following requirements in order to receive FY 2007-2008 funding:

- Hospitals must be in 80% compliance with reporting to the State Medical Asset Resource Tracking Tool (SMARTT).
- EMS Systems must be in compliance by participating in PreMIS (80%) and reporting to SMARTT (75).
- Hospitals and EMS systems participating in a minimum of 50% of their RAC Disaster Preparedness Committee (DPC) meetings in grant year 2006-2007.
- Hospitals participating in some capacity with the State Medical Assistance Team (SMAT) II program.
- Hospitals must be compliant with all audit reporting requirements. In accordance with GS143-6.2, funding will not be provided to hospitals listed by the State Controllers Office on the Suspension of Funding List.
- SMAT IIs and IIIs must meet the requirements outlined in the MOU (Teams that do not meet these requirements may provide a Performance improvement plan outlining a plan to achieve compliance during this grant period) Funding allocations for teams that do not comply with the current MOU will be evaluated on an individual basis.
- SMAT IIIs must have a completed 2007 SMAT III survey on file with OEMS.

- *Step 2*

  Regional DPRGC submit final project recommendations to the RAC Emergency Response and Recovery Coordinator based on eligibility requirements.

- *Step 3*

  Complete RAC grant application.

- Complete application cover sheet.
- Complete the Project Narrative Form for each of the projects selected. The Project Narrative will be the primary document used by NCOEMS in determining the fundability of a project. The Project Narrative will be used to complete the project objectives, produce deliverables and describe the budget.
- NIMS statement outlining current compliance and proposed plan to reach total capability element compliance
- Signed copy of Current SMAT II MOU
- Contact information for the following:
  - RERRC
  - Contract representative
  - Financial Representative

* All communications projects/equipment must be approved by NCOEMS

* Education/training must be competency based and approved by NCOEMS

The following are required for each Project Narrative Form:

Capability Heading

Statement of Current Capability Status

Project Title

Project Leader & Contact information

Proposed Contractor (if available)

Needs Statement

Goal Statement

Itemized Project Objectives

Detailed Narrative Explanation of the Project: A brief description of how the project will be accomplished. Included in the narrative should be how the TCL and the State and County HVAs and the HRSA 2005 – 2006 Survey

will be used to close capability gaps. The goal of the narrative is to help program managers, reviewers, and other interested parties understand what the project does. The narrative must address:

1. That not only that the capability element and its associated components are eligible for funding but they must be clearly linked to a State or County HVA or HRSA Grant 2005 - 2006 Survey gap analysis to show that there is still an unmet need.
2. Each capability and sub-capability element and its associated components must be linked to the specific TCL's Critical Task that it is addressing

Project Relevance to all Overarching sub-capabilities by heading

1. NIMS
2. Education and Preparedness Training
3. Exercises, Evaluation, and Corrective Action
4. At Risk Population

Performance Measures and Timelines: Must show how the RAC will provide ongoing monitoring and reporting of project accomplishments, particularly progress towards completing the projects objectives or deliverables. The Performance Measures should identify measurable outcomes to include significant project milestones, completions dates and the associated Critical Task's Performance Measure.

Budget and Budget Narrative

Entity/Entities Receiving Funding & Project Coordinators

P/P #

Critical Task: Number and description of Critical Task

Sub-Capability Element(s): Level 1 and /or Level 2 sub-Capabilities

Capabilities Based Planning Element(s): Personnel, Planning, Equipment & Systems, Training or Exercise, Evaluation & Corrective Action.

- *Step 4*

  Complete one Composite Budget Form summarizing total for Grant Application on Forms provided by the NCOEMS

- *Step 5*

After application is completed, the Emergency Response and Recovery Coordinator shall submit an electronic copy (MS Word version) of the application to their NC OEMS Regional Disaster Medical Specialist for review no later than October 26, 2007. Each RAC will be assigned a formal review time of approximately two hours with NC OEMS staff in Raleigh on either November 5 or 6, 2007. After this meeting and any subsequent revisions, **TWO ORIGINAL** signed applications shall be completed and delivered to the NC OEMS Disaster Medical Coordinator no later than November 14, 2007 for contract execution.

Steps 1 through 5 must be completed by November 14, 2007. No funds shall be expended until the contract has been fully executed.

During the term of the contract grantees must submit monthly progress and expenditure reports even if no activity has taken place. These reports shall be submitted on forms provided by the NC OEMS. All expenditures must be completed by July 18, 2008. A final narrative, financial report and all final invoices must be submitted to the NCOEMS by September 8, 2008.

All grant contracts will expire on August 8, 2008.